

Section 1

Defining Your Needs and Eligibility

Health care coverage is always evolving, and health insurance and health care access issues are increasingly complex in today's market. You must be sure that the health care system you choose meets your needs.

Different kinds of health coverage plans are available based on your current needs, personal circumstances and financial resources. This section is organized around discovering what kind of policy or plan you may need, are eligible for, and can afford.

Consumers who might need to turn to the individual market to purchase health care coverage include those who do not have insurance through their own employment or that of a spouse or parent. While a large percentage of people do have their primary health coverage through an employer, there is an increasing population of individuals who do not have access to employment-related benefits.

What if your employer's health plan does not meet your needs? Perhaps the plan doesn't cover your spouse or dependents, is too expensive, or you haven't worked long enough in the company to qualify. Or you may have to wait for an "open-enrollment" period (usually the same month each year). In those cases, you may want to look into buying your own individual policy.

Real-life situations in which entering the individual market for health care coverage may be necessary:



- You just moved to Washington from another state and need insurance.
- You will no longer be covered under your parents' policy.
- The rates for family health insurance through your employer are too high for all of you to be covered. If you continue on your employer's plan, you need coverage for your spouse and/or children.
- Your kids need insurance to play sports at school.
- You are self-employed and don't have health insurance.
- You work one or more part-time jobs, and none offer benefits.

Check with your plan administrator to find out if your employer's plan is subject to Washington State Insurance regulation as described in this guide. Some types of plans, including self-funded and union trust plans, are exempt from state regulation.

Employment-related Coverage

If you are currently employed, you might qualify to purchase the following types of coverage:

- **Group plans**

If either you or your spouse are working, you may be able to obtain health benefits through the employer. Unlike those enrolling in an individual plan, if you are enrolling in a group plan you do not have to take the health screen as explained on page 8. Group plans cannot reject you based on health status. For more information, check with the plan's administrator.

- **Self-employed**

If you are self-employed or a sole proprietor, you may be eligible for a small group plan. Single-proprietor businesses or self-employed people qualify as "groups of one." Washington state law allows single-owner businesses to buy in the group market, even though the only people covered under the plan will be the business owner and his or her dependents.

To be eligible for small group rates, you must:

- **derive at least 75%** of your income from your business, and;
- **have filed the IRS Form 1040**, Schedule C or F, during the preceding year.

If you meet these requirements you cannot be turned down by a health carrier for small group coverage. Some carriers have not been eager to market these plans, but state law requires they be available. Consumers who encounter resistance may contact the OIC for advice or assistance at 1-800-562-6900.

- Professional organizations and association plans

Another kind of group plan is sometimes offered through professional organizations, such as local realty boards or the chamber of commerce. These so-called “association plans” are often accessible to people in a particular industry, professional group, or business association. Additionally, you may be eligible for health insurance through a religious or fraternal organization.

Although they may share some characteristics of group plans, many association plans are not regulated by the OIC, or are regulated differently than traditional health plans. Therefore, your rights and legal protections may be limited.

Be sure you fully understand the exact scope of benefits you are purchasing. While association plans are offered statewide, sometimes at very competitive rates, disappointments are common among subscribers who were not aware of a plan’s limitations and exclusions.

Association plan subscribers may wish to consider purchasing riders to the basic coverage, to ensure a more complete package of benefits. It is also important to get benefit information in writing.

For more information on these options, please visit the OIC web page at www.insurance.wa.gov or call the Consumer Hot Line at 1-800-562-6900, or SHIBA HelpLine at 1-800-397-4422.

- COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed in 1986. It provides for availability of health benefits to employees who are terminated or lose medical coverage because their hours are reduced. Group health plans provided by companies with 20 or more employees are subject to COBRA.

If you are leaving your job, divorcing an employed person, or otherwise being separated from an employment-related plan, you should ask the employer if you are eligible for COBRA benefits. COBRA enrollees can continue benefits at their own cost for up to 18 months. Spouses and dependents can continue benefits for 18-36 months, depending on their circumstances.

If an employee, spouse, or dependent was covered by the group health plan on the day before a qualifying event (see below), then the employee, spouse, or dependent may be eligible to buy continued coverage under the group plan for 18-36 months, depending on the qualifying circumstance.

A qualifying event for an employee is reduction in hours or losing a job for reasons other than “gross misconduct.”

A qualifying event for a spouse or dependent includes reduction in hours or termination of the covered employee (as described above), plus:

- ◆ **Divorce** or legal separation from the covered employee
- ◆ **Death** of the covered employee
- ◆ **Entitlement to Medicare** by the covered employee
- ◆ **Loss of “dependent child status”**

Beneficiaries must pay for COBRA coverage themselves. They may be charged up to 102 percent of the total cost of the group plan, which includes the portion usually paid by the employer.

In June 1998, the U.S. Supreme Court ruled that COBRA coverage may not be denied when other group health coverage is present on or before the COBRA election day. An individual who already has other coverage (including Medicare) on or before the date he or she becomes eligible for COBRA may continue that coverage along with COBRA coverage.

But if an individual qualifies for Medicare **after** qualifying for COBRA coverage, the employer may terminate the COBRA coverage. Not all plans terminate COBRA coverage immediately upon Medicare eligibility, so check with the plan administrator.

Warning: If you are enrolled in Medicare Part A (hospital coverage) and you elect COBRA but fail to enroll in Medicare Part B (medical coverage), you may be subject to penalties and to a delay in coverage under Part B when your COBRA expires. This delay in coverage could leave you without medical insurance for up to 16 months, depending on the date your COBRA expires.

The federal Centers for Medicare and Medicaid Services (CMS), which administer the Medicare program, also publish helpful guides such as *Medicare & You*. Visit them on the Web at: www.medicare.gov or call 1-800-MEDICARE.

Depending on circumstances, dependents may be able to continue COBRA coverage even if the primary employee (ex-employee) becomes Medicare-eligible.

Continuation Coverage is a limited form of COBRA for consumers leaving small employers with 20 or fewer employees.

For more information on COBRA, call the Department of Labor (DOL) Employee Benefits Security Administration at 1-866-275-7922 or check with your employer’s Human Resource office.

Coverage for Individuals and Families

If you need health insurance and are not eligible for Medicare, there are several kinds of insurance coverage available:

- Individual and family plans from commercial health plans
- Individual and family plans sponsored by government agencies

Commercial Health Plans

Currently, there are two general types of health insurance policies being sold in Washington state.

1. **Managed care plans**, often known as Health Maintenance Organizations (HMOs).
2. **Fee-for-service** or indemnity plans.

Each type of policy has its pros and cons. Here is how they work:

• Managed care

Most health insurance sold in Washington state today operates under the principle of managed care. Managed care is a philosophy of providing health care at the most efficient level. Typically, managed care systems restrict their subscribers to a specified network of providers, and require subscribers to deal with a “gatekeeper” who tries to make sure that patients do not receive inappropriate health services or undergo procedures unnecessarily.

Managed care plans require consumers to obtain their health care from a large organization or network of professionals. You visit a physician you have chosen from among the managed care plan’s network of providers.

Managed care systems may differ greatly from one another. Some allow more freedom than others when selecting a personal physician or other specialist. They also may use different systems of “co-payment” (a small, upfront charge the consumer pays during an office visit). Depending on your personal circumstances, these differences may be important to you. Ask about the features of any plan before you enroll and be sure you understand how they work.

Remember: You can quickly locate help by calling our toll-free Consumer Hot Line at **1-800-562-6900**.

A managed care premium often covers educational/wellness programs and some preventive exams and routine services, along with diagnostic services and treatment. Your fixed monthly premium (if any) pre-pays as much care as is medically necessary.

With managed care, out-of-pocket expenses come in the form of plan-specified co-payments for some services. These often range from \$5 to \$20 per visit. For services not approved/covered by the plan, you pay the full amount. The plan usually coordinates bills and payments.

- **Fee-for-service/indemnity**

Fee-for-service plans allow consumers to act independently in choosing health care professionals and hospitals.

The “fee-for-service” system is a pay-per-visit arrangement. You see any licensed provider you choose when you need a treatment, service or exam. You are billed each time you receive care. Depending on the service, and your insurance coverage, your policy will cover part of the bill or none. Doctors and other providers in individual or group practice are paid by the insurance company for each service (e.g., office visit, tests).

Usually there is a deductible (amount you pay out of your own pocket before your coverage “kicks in”). You are also responsible for coinsurance (a percentage of expenses that you must pay each time a service or treatment is rendered) and any out-of-pocket expenses (the full fees for services not covered by your insurance). How much of these expenses you pay out of pocket depends on the extent of your insurance coverage.

Health Screening and the Individual Market

Under a law passed by the Legislature in 2000, insurers may now impose a waiting period for coverage of pre-existing health conditions. A nine-month waiting period applies to any pre-existing condition for which you were treated, or for which a prudent layperson would have sought advice or treatment, during the previous six months.

If the plan you held just before you got the new coverage was equivalent to, or better than, the new plan, the carrier must credit the time you were enrolled under that plan toward the waiting period for the pre-existing condition. For example, if you had nine months of such coverage under your immediately preceding plan, your waiting period would be waived. If you had four months of coverage, you still would have to wait five months for the new insurance to cover a pre-existing condition.

If you have 18 months of creditable coverage and otherwise qualify as an “eligible individual” under federal law, then insurers may not impose a pre-existing condition waiting period before your coverage begins.

Also, the 2000 legislation requires most applicants in the individual market to complete a comprehensive health questionnaire. When you contact a health plan, the application packet you receive will include the health questionnaire. If your score on that questionnaire exceeds the level below which the health plan must cover you, the company may reject your application. This rejection automatically makes you eligible for health insurance through the Washington State Health Insurance Pool (WSHIP).

The health questionnaire is designed to screen out the 8 percent “most costly” applicants into WSHIP. The premiums for WSHIP coverage are higher than those of commercial health plans. WSHIP members can choose between network and fee-for-service plans, and select from different deductible amounts. Discounts also may be available under some circumstances.

For questions about the health screen questionnaire, its scoring, and WSHIP coverage and rates, call WSHIP at 1-800-877-5187, or visit the WSHIP Web site at www.onlinehealthplan.com/oasys/wship/

Individuals Not Required To Take the Health Screen

The new law generally applies to anyone buying new coverage without previous coverage. However, certain consumers will not be required to undergo health screening. They include:

- **People who have exhausted COBRA coverage or lost it because their former employer has gone out of business.** (This does not mean people have to wait for their COBRA coverage to expire before applying to a new plan. In fact, consumers should apply in advance, because new coverage typically will not begin for 30 days.)
- **People seeking a different product** because they are relocating from one area to another within Washington state.
- **People who are applying for new coverage** in order to stay with the family doctor.

Plans Sponsored by State and Federal Agencies

In general, these plans are meant to help people who cannot afford insurance in the individual market or have very expensive health care needs. Some programs are specifically meant for people who are disabled or who have limited incomes and resources. Often, people are not aware of their eligibility for these programs.

Basic Health

The state of Washington subsidizes a public health program called Basic Health (BH) for Washington state residents whose income is too high to qualify for public assistance (Medicaid), but too low to afford individual coverage.

BH is a managed care plan sponsored by the state and administered through private insurance carriers. It is a comprehensive health plan covering prescription drugs, maternity, and major medical costs. However, it does not cover registered physical therapy, eye and hearing exams, artificial limbs, or medical equipment such as wheelchairs or back braces. As is typical of managed care, you must use the services within a network of providers in your area. Besides paying a monthly premium, you will have to make a small co-payment each time you visit your health care provider.

Currently, there is a general “wait list” for adult enrollment. There are a few exceptions to this general rule. For more information, to have your name added to the waiting list, or to ask if you qualify for an exception, call Basic Health: 1-800-826-2444. Or check the Web site: **www.basicealth.hca.wa.gov**

If you meet the income qualifications, you may be eligible for the Basic Health reduced premium program. Benefits, rates, and other details are available by calling 1-800-826-2444 or visiting the BH website at **www.wa.gov/hca/basicealth.htm**

BH may be available for children. For more information, see “Coverage for Kids” elsewhere in this guide.

Medicaid

Medicaid is a publicly-funded program that provides health insurance to specific categories of people who meet financial eligibility requirements. Medicaid was created by the federal government and is usually administered by state governments. The federal government (the Centers for Medicare and Medicaid Services [CMS], formerly the Health Care Financing Administration [HCFA]) provides oversight and some funding to Medicaid programs.

In Washington state, Medicaid programs are administered by the Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS). These programs are offered through a number of local Community Service Offices.

Medicaid is actually a complex system of programs, requirements and benefits. There are many different Medicaid programs for specific eligibility groups. In Washington, those groups are pregnant women, children, disabled individuals and persons over the age of 65 (“the aged”). In some limited instances, certain people who do not fall into these categories may be eligible for limited emergency coverage (if they have no other coverage).

Listed below are the main types of Medicaid programs offered to different categories of individuals. This chart is designed to provide you with a quick reference to these programs.

Due to the variety of eligibility requirements for different programs, DSHS recommends that you review your eligibility online at <http://fortress.wa.gov/dshs/maa/eligibility/index.html>. You can also talk to a customer service representative. Call 1-800-865-7801 to determine the location of the Community Service Office nearest you.

Medicaid Program	Eligibility
Categorically Needy Program (CN)	Aged, blind, disabled, pregnant women, and children who meet income requirements.
General Assistance Program	Some persons who are eligible for Alcoholism/Drug Treatment Services and those who are classified “unemployable” due to a physical or mental disability.
Long Term Care and Community Options Program Entry System (COPES)	Persons who are in need of (or at risk of) being institutionalized in a nursing home (must meet financial guidelines).
Alien Emergency Medical (AEM)	Children, parents with dependent children, and disabled adults who are ineligible for other Medicaid programs due to immigration status.

Healthy Options

Healthy Options is the name of the Medicaid managed care program. Under Healthy Options, a consumer is enrolled in a health plan and needs to have a Primary Care Provider (PCP). Consumers need referrals for specialist care.

Unless you receive SSI, Medicare, or qualify for an “exemption” from Healthy Options, Medicaid recipients must enroll if they are:

- **a parent or relative** caring for a child or children, or
- **a child under age 19**, not in foster care, or
- **pregnant.**

Exemptions from Enrollment:

An exemption from Healthy Options can allow consumers to get medical care from their choice of providers who take medical coupons, without being limited to a single plan or PCP. You may qualify for an exemption if you:

- **have good reason why** care is not reasonably available under any plan. For example, the plan cannot meet a specialized health care need (and it is documented by the current provider);
- **are pregnant and already being seen** by another provider who is not in a plan;
- **are homeless;**
- **have a provider who is not in a plan**, and disrupting the treatment plan might be harmful to your health;
- **have a hardship getting care** from a plan because of distance or travel time;
- **already have a provider who speaks** your first language and cannot find a provider in the plan who does;
- **are a Native American or Alaska Native**, in which case you are automatically exempt and are only enrolled in Healthy Options if requested;
- **have managed care coverage** through medical insurance other than Medicaid.

You may request an exemption by calling 1-800-794-4360, or by contacting your DSHS caseworker. It is best to submit a written request with supporting medical or other evidence.

If DSHS denies the exemption, they must send you a notice explaining the reasons and your right to a fair hearing.

For more information on Medicaid and Healthy Options, you can go to <http://hcfa.hhs.gov/medicaid/mcaicnsm.htm> or www.wa.gov/dshs/maa/index.html

Washington State Health Insurance Pool (WSHIP)

As stated earlier in the discussion of health screening in the individual market (page 8), the Washington State Health Insurance Pool (WSHIP) provides health insurance for people who are unable to obtain individual coverage in the private marketplace. This plan provides comprehensive coverage, including a prescription drug benefit. Premiums are based on age and type of plan selected.

You are only eligible for this plan if you have failed the health screen for individual coverage (see page 8). If you do fail the health screen, the carrier you applied to will automatically send you an application for WSHIP.

There are two WSHIP options available for people who are *not* on Medicare:

- The Standard Plan (Plan 1), which is fee-for-service, allows you to go to the doctor of your choice;
- The Network Plan (Plan 3) uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (Plan 2.) This plan has different eligibility criteria.

In the fee-for-service plan, rates are set at 150% of the average market rate for comparable commercial coverage. Rates for the network plan (managed care) are 125% of the average market rate.

Some discount rates will be given to people age 50-64 with low income, people who have been continuously insured with their previous plan, and people who have been in WSHIP for more than three years. For further information about WSHIP, contact the administrator, OASYS: **1-800-877-5187** or www.onlinehealthplan.com/oasys/wship/



Coverage for Kids

More than 100,000 children and teenagers in Washington state are without health insurance. However, there are several insurance programs available especially for children.

Basic Health Plus

Basic Health Plus is a Medicaid program for children in low-income households. There are no copayments for services and no monthly premium; DSHS pays the entire cost of coverage. It offers added benefits and services for children, including vision and dental benefits, and transportation to medical services.



If you are on Basic Health, your children may be eligible for Basic Health Plus. They must be under age 19 and U.S. citizens, or legal residents who arrived in the U.S. before Aug 22, 1996.

Children not living in your household may be enrolled in Basic Health (see page 10) but not Basic Health Plus.

For more information call **1-800-826-2444** or visit the Basic Health website at: www.wa.gov/hca/basichealth.htm

Children's Health Insurance Program (CHIP)

Children's Health Insurance Program (CHIP) is a federal/state program that covers children under age 19 in families whose income is too high for Medicaid and Basic Health, but below 250% of the Federal Poverty Level (FPL). Many children who don't qualify for Basic Health are eligible for CHIP. A family must meet income limits to qualify for CHIP. These income limits represent gross monthly household income minus childcare and other approved deductions.

While CHIP is technically not a Medicaid program, it is administered by the same state government office (Department of Social and Health Services) as Medicaid programs. When consumers apply for CHIP, the children are considered for Medicaid first. If the children are not eligible for Medicaid because of income, DSHS will then check to see if the family income fits within the CHIP income guidelines. If children are eligible for Medicaid, they are not eligible for CHIP. This program has no resource limits.

For more information about CHIP, go to <http://www.hcfa.gov/init/children.htm> or call toll free at **1-877-543-7669**.